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Unannounced Inspection Report

Mental Health Services Safe Delivery of Care Inspection

Western Isles Hospital

NHS Western Isles

17 – 18 February 2026

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About our inspection

Background

The current Healthcare Improvement Scotland Adult Mental Health inspection programme was developed as part of a range of actions to support and improve NHS adult mental health services in Scotland in the context of the COVID-19 pandemic and beyond. Although the initial focus of this work was on Infection Prevention and Control, it was agreed with Scottish Government to broaden the inspection focus from infection prevention and control to a broader assurance function, creating a new and revised 'safe delivery of care' assurance model in NHS adult mental health units.

Our revised methodology will incorporate the HIS Quality Assurance System Quality Assurance Framework and framework and will consider a wide range of standards such as the Health and Social Care Standards (2017) and the new Core Mental Health Quality Standards and indicators (2024)

Further information about the methodology for adult mental health inpatient services safe delivery of care inspections can be found on our website.

Our Focus

Our inspections consider the factors that contribute to the safe delivery of care. In order to achieve this, we:

- observe the delivery of care within the clinical areas in line with current standards and best practice
- attend hospital safety huddles
- engage with staff where possible, being mindful not to impact on the delivery of care
- engage with management to understand current pressures and assess the compliance with the NHS board policies and procedures, best practice statements or national standards, and
- report on the standards achieved during our inspection and ensure the NHS board produces an action plan to address the areas for improvement identified.

About the hospital we inspected

NHS Western Isles provides a range of healthcare services to the population of the Western Isles. Western Isles Hospital is a rural general hospital located in Stornoway and is the largest of the three hospital services within NHS Western Isles. Western Isles Hospital opened in 1992 with a range of specialties such as general surgery, paediatrics, maternity and psychiatry. The hospital also includes diagnostic facilities, day hospital (ambulatory care unit), laboratory, allied health

professionals and other services. The Acute Psychiatric Unit has five inpatient beds and is the only inpatient mental health service within NHS Western Isles. The Acute Psychiatric Unit provides care for those suffering from acute mental illness who require assessment and enhanced support in an inpatient environment.

An unannounced inspection of acute wards in Western Isles Hospital took place in September 2024 which made a number of requirements regarding areas for improvement to the board. The follow up inspection in October 2025 identified significant progress but with some areas for improvement remaining. The maternity NHS inspection team also inspected maternity services in the Western Isles hospital in October 2025 which highlighted both good practice and a number of areas for improvement. Although we inspected only mental health services during this inspection, reference to relevant areas for improvement identified in the previous inspections will be highlighted throughout the report.

About this inspection

We carried out an unannounced mental health services inspection to Western Isles Hospital, NHS Western Isles on Tuesday 17 February 2026 using our safe delivery of care inspection methodology. We inspected the following areas:

- Acute Psychiatric Unit

During our inspection, we:

- inspected the ward and hospital environment
- observed staff practice and interactions with patients, such as during patient mealtimes
- spoke with patients, visitors and ward staff, and
- accessed patients' health records, monitoring reports, policies and procedures.

As part of our inspection, we also asked NHS Western Isles to provide evidence of its policies and procedures relevant to this inspection. The purpose of this is to limit the time the inspection team is onsite, reduce the burden on ward staff and to inform the virtual discussion session.

On Monday 16 March 2026, we held a virtual discussion session with key members of NHS Western Isles staff to discuss the evidence provided and the findings of the inspection.

The findings detailed within this report relate to our observations within the areas of the hospital we inspected at the time of this inspection.

We would like to thank NHS Western Isles, and in particular all staff at the Acute Psychiatric Unit for their assistance during our inspection.

A summary of our findings

Our summary findings from the inspection, areas of good practice and any recommendations and requirements identified are highlighted as follows. Detailed findings from the inspection are included in the section 'What we found during this inspection'.

Staff in the Acute Psychiatric Unit had high levels of compliance with mandatory eLearning. However, the practical elements of mandatory training, including immediate and basic life support and violence and aggression training, were identified as requiring improvement.

Staff were delivering trauma informed interventions to reduce distress and promote wellbeing.

We observed good compliance with infection prevention and control standards.

The introduction of best practice policies for continuous intervention, seclusion and ligature risk management should be supported by training plans to ensure staff can deliver safe and effective patient care in the least restrictive environment.

We observed challenges due to the remote and rural location and the capacity of inpatient mental health services in the Western Isles. This includes challenges in accessing beds for those with complex needs and those who require specialist treatment.

During the acute hospital inspection in September 2024, concerns were raised with NHS Western Isles regarding the governance and review of policies and procedures. In evidence provided during this inspection we also observed that within mental health services, several policies and procedures were out of date, in draft form and with no target publication date or date for review. Other areas of improvement include completion of patient documentation including evidencing therapeutic activity and the documentation of ongoing risk and risk management.

What action we expect the NHS board to take after our inspection

This inspection resulted in two areas of good practice and 17 requirements.

A requirement in the inspection report means the hospital or service has not met the required standards and the inspection team are concerned about the impact this has on patients using the hospital or service. We expect all requirements to be addressed and the necessary improvements implemented.

A recommendation relates to best practice which Healthcare Improvement Scotland believe the NHS board should follow to improve standards of care.

We expect NHS Western Isles to address the requirements. The NHS board must prioritise the requirements to meet national standards. An improvement action

plan has been developed by the NHS board and is available on the Healthcare Improvement Scotland website: www.healthcareimprovementscotland.scot

Areas of good practice

Domain 6	
1	Staff deliver trauma informed interventions to help manage distress and maintain safety (see page 29).
2	A patient feedback questionnaire has been developed and is being rolled out to measure patient experience within the Acute Psychiatric Unit (see page 29).

Requirements

Domain 1	
1	NHS Western Isles must ensure effective and appropriate governance approval and oversight of policies and procedures are in place (see page 19). This will support compliance with: Quality Assurance System (2022) Criterion 4.1 and relevant codes of practice of regulated healthcare professions.
2	NHS Western Isles must ensure staff are supported to care for patients that are not aligned with their specialty (see page 19). This will support compliance with: Health and Social Care Standards (2017) Criteria 3.14 & Core Mental Health Standards (2023) Criteria 2.3
3	NHS Western Isles must ensure there are clear processes in place to ensure patients can access appropriate inpatient care when their needs are complex and cannot be met in current inpatient mental health facilities in the Western Isles (see page 19). This will support compliance with: Core Mental Health Standards (2023) Criteria 3.5
4	NHS Western Isles must ensure that all staff are suitably qualified and competent to safely carry out their role through compliance with mandatory and role specific training, including but not limited to, immediate and basic life support, management of violence and aggression, continuous observations and the safe use of seclusion (see page 19). This will support compliance with: Health and Social Care Standards (2017) Criteria 3.14 & Core Mental Health Standards (2023) Criteria 2.3 & 4.1 & The Mental Health (Care and Treatment) (Scotland) Act 2003
5	NHS Western Isles must ensure compliance with Safety Action Notice 2403 and staff can identify and mitigate the risk posed by plastic bags in the unit (see page 19).

	This will support compliance with: Health and Social Care Standards (2017) Criteria 5.19 & NHS Scotland Assure Safety Action Notice (SAN) 2403
6	NHS Western Isles must ensure staff are trained in ligature risk management in line with NHS Western Isles Ligature Risk Reduction Procedure for the Acute Psychiatric Unit (see page 19). This will support compliance with: Health and Social Care Standards (2017) Criteria 5.19 & 3.14
7	NHS Western Isles must ensure staff carry out mandatory fire evacuation training in line with fire safety risk assessment (see page 19). This will support compliance with: NHS Scotland 'Firecode' Scottish Health Technical Memorandum SHTM 83 (2017) Part 2; The Fire (Scotland) Act (2005) Part 3, and Fire Safety (Scotland) Regulations (2006).

Domain 2	
8	NHS Western Isles must ensure learning from all incidents is used to improve safety and outcomes for patients and staff (see page 22). This will support compliance with: Health and Social Care Standards (2017) Criteria 4.19 & The National Framework for Reviewing and Learning from Adverse Events in NHS Scotland (2025)
9	NHS Western Isles must ensure clear assurance processes and systems that identify required learning and actions taken to support improvement (see page 22). This will support compliance with: Health and Social Care Standards (2017) Criteria 4.19 &

Domain 4.1	
10	NHS Western Isles must ensure that all patient documentation is clear, and accurately and consistently completed with ongoing actions recorded. This includes clear identification of risk and ongoing risk management (see page 24). This will support compliance with: Quality Assurance Framework (2022) & relevant codes of practice of regulated healthcare professions.
11	NHS Western Isles must ensure there is oversight and consistent application of screening tools to identify patient risk of pressure damage in the Acute Psychiatric Unit (see page 24).

	This will support compliance with: Healthcare Improvement Scotland's standards for the prevention and management of pressure ulcers (2020)
12	NHS Western Isles must ensure they have systems in place to assure themselves that essential maintenance works are completed timeously, the care environment is maintained to allow for effective cleaning and any risks to patients and staff are identified and managed (see page 24). This will support compliance with: Health and Care Social Standards Criterion 5.19 & 5.24

Domain 4.3	
13	NHS Western Isles must ensure sufficient staffing, with the right staff in place to support patient safety and staff wellbeing (see page 27). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019
14	NHS Western Isles must ensure that there are processes in place to support the consistent application of the common staffing method. This includes ensuring that the principles of the common staffing method are applied, including having a robust mechanism for feedback to be provided to staff about the use of the common staffing method, and staffing decisions made as a result (see page 27). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019

Domain 6	
15	NHS Western Isles must ensure all patients are involved in planning their own care and this should be documented (see page 29). This will support compliance with: Health and Social Care Standards (2017) Criteria 2.1 & Core Mental Health Standards (2023) Criteria 2.7
16	NHS Western Isles must ensure meaningful activity is consistently provided and evidenced within care planning documentation (see page 29). This will support compliance with: Quality Assurance Framework (2022) Criteria 2.2 & Health and Social Care Standards (2017) Criteria 2.21 and 2.22
17	NHS Western Isles must ensure that patients' privacy and dignity is maintained, including having appropriate safe, lockable bedroom doors that support dignity and privacy (see page 29).

This will support compliance with: Health and Social Care Standards (2017) Criteria 5.1

What we found during this inspection

Domain 1 – Clear vision and purpose

Quality indicator 1.5 – Key performance indicators

NHS Western Isles faces unique challenges due to the remote and rural nature of mental health service delivery. This includes access to services for those with complex needs. Areas for improvement include compliance with mandatory staff training.

NHS Western Isles provides mental health services to people across the Outer Hebrides. The Acute Psychiatric Unit is situated within Western Isles Hospital in Stornoway. Mental health care is also provided across the islands by community mental health teams. The Acute Psychiatric Unit provides five inpatient beds for the assessment and treatment of adults with functional mental illness. The term functional refers to mental health disorders other than dementia. The criteria for admission is outlined in NHS Western Isles Acute Psychiatric Unit admission policy. Admission is through NHS Western Isles community mental health teams, the accident & emergency department or from the acute medical wards within Western Isles Hospital. In evidence provided we observed clear pathways and criteria for admission to the Acute Psychiatric Unit. However, the admission policy was overdue for review since August 2025. All planned admissions are reviewed by the consultant psychiatrist. Unplanned or emergency admissions within normal business hours are assessed by the community mental health team or the psychiatric liaison service. Out with normal business hours patients are assessed by the on-call consultant psychiatrist.

Psychiatric Emergency Plans are locally agreed arrangements and procedures outlining the role and responsibilities of police, health, social work, and other partners who may potentially be involved in responding to and managing a psychiatric emergency, with consideration for what support is available to prevent escalation to a detention under the Mental Health (Care and Treatment) (Scotland) Act 2003. A national review of Psychiatric Emergency Plans is underway following the Mental Welfare Commission's Review of Psychiatric Emergency Plans in 2020. NHS Western Isles provided Psychiatric Emergency Plans 2019-2022. Senior managers also provided evidence that the board is awaiting the outcome of the national review before carrying out a further update.

Other key mental health policies were also overdue for review or remained in draft form including the local framework for adverse event reporting, management and learning, the admission policy, the continuous intervention and short-term seclusion policy and the ingress and egress policy.

In September 2024, Healthcare Improvement Scotland undertook an unannounced safe delivery of care inspection of Western Isles Hospital acute

wards. During that inspection several guidelines and standard operating procedures which were in draft form or had no approval or review date were provided by the board. Governance and oversight processes were raised in a letter of serious concern sent to NHS Western Isles at that time. This requirement was met in the follow up inspection in October 2025. While we recognise that delays in some policies within mental health services may be due to national reviews being undertaken, NHS Western Isles must ensure that policies and guidelines are current and there is evidence of regular review. A requirement has been given to support improvement in this area.

At the time of inspection, the ward was staffed by registered mental health nurses. There were patients admitted to the unit with one patient on pass. A patient on pass is an inpatient who is temporarily absent from a ward, by arrangement. Staff told us that the unit did not use additional beds. However, during periods of high occupancy, mental health patients may be cared for on medical wards within the hospital due to bed pressures within the Acute Psychiatric Unit or across Western Isles Hospital. This involves a discussion with ward staff and senior staff to consider the risks and suitability of any move. Patients spend the day in the Acute Psychiatric Unit and only sleep in the medical wards overnight. This arrangement helps ensure continued access to therapeutic intervention and recovery support from staff in the Acute Psychiatric Unit.

From the evidence provided, we observed that there was one patient cared for in medical wards over the past 12 months and two patients who were cared for in the Acute Psychiatric Unit from general medical wards. NHS Western Isles shared with us their standard operating procedure for internal patient transfer within Western Isles Hospital. This highlighted that only patients who are assessed as low risk, using the patient transfer matrix within the standard operating procedure, are considered for transfer when necessary. It also outlined that discussions would take place between senior medical staff, the clinical support nurse and the ward teams prior to agreeing any transfer. Clinical support nurses provide 24-hour senior nursing cover for Western Isles Hospital. Senior managers confirmed that patients transferred internally are typically those who are awaiting discharge. Patients with an on-going clinical need should remain in their admitting ward and would not be considered for transfer. We did not identify any evidence of adverse events or incidents relating to internal patients transfer.

Staff told us of the challenges for both patients and staff when caring for patients with dementia in the Acute Psychiatric Unit. For example, patients with middle or late-stage dementia may require more assistance with comprehension, orientation and personal care. Those with functional illness may not understand unpredictable behaviours from others, and this may heighten anxiety and agitation. There is potential for increased workload and stress on staff as they must manage a wide range of behaviours, requiring different approaches for different patient groups. This is supported by findings in the Mental Welfare Commission report on older people's functional mental health wards in hospitals

(2020) who highlighted that mixing patients who are solely diagnosed with dementia with those who do not have that diagnosis is challenging and does not meet the needs of either group.

Staff told us that the admission of people to the Acute Psychiatric Unit with a dementia diagnosis has increased since the closure of the specialist dementia ward in late 2018. Senior managers explained that admissions of people with dementia are infrequent and usually due to system pressures across NHS Western Isles. We observed that six patients under the care of psychiatry of old age were admitted to the Acute Psychiatric Unit in 2025. However, we were advised that not all these patients had a diagnosis of dementia. Staff told us that patients admitted to the unit are often awaiting care home placements and are identified as having a delayed discharge. Delayed discharge refers to situations where a patient is clinically ready to leave hospital but cannot do so because the required care, support, or accommodation is not available. Staff explained that patients experiencing delayed discharge can remain in the unit for extended periods and that it can be challenging to provide appropriate care for the differing needs of patient groups within the unit. Within evidence reviewed, we identified one incident report relating to a patient with dementia. We asked senior managers how staff were supported to provide care for this group of patients. They told us that most staff within the Acute Psychiatric Unit have experience of caring for this patient group. However, there is no ongoing training or support in relation to working with patients with a diagnosis of dementia. NHS Western Isles must ensure staff can access the most current evidenced based practice to provide safe and effective care for all patients admitted to the Acute Psychiatric Unit. A requirement has been given to support improvement in this area.

Specialist admissions to the Acute Psychiatric Unit include planned alcohol detoxification. Senior managers provided us with NHS Western Isles' pathway for inpatient detox to the Acute Psychiatric Unit. This shows collaborative working with the NHS Western Isles community substance services and staff within the Acute Psychiatric Unit. Senior managers explained that staff within the Acute Psychiatric Unit have all attended training in relation to the inpatient alcohol detoxification pathway. The Clinical Institute Withdrawal Assessment for alcohol revised (CIWA-Ar) is currently in use across the wider hospital to measure withdrawals from alcohol in a safe and consistent way. These are used to reduce symptoms of withdrawal and prevent the development of serious withdrawal effects such as seizures and delirium tremens. However, this tool is currently under review, and the implementation of the Glasgow Assessment and Management of Withdrawal Scale is being considered for use across the hospital, including in the Acute Psychiatric Unit.

Rural and island communities face distinct mental health challenges relating to recruitment and retention of skilled staff, impacted by the remote geography. Within NHS Western Isles' corporate risk register, the lack of access to mainland acute mental health beds for patients that require transfer due to complex and

challenging needs is identified as very high risk. Mitigations include highlighting the risk with both Scottish Government and the Mental Welfare Commission. Following a Mental Welfare Commission visit in April 2025 a recommendation was given regarding access to suitable specialist beds including safe transfer arrangements as and when required for people in the Western Isles. Senior managers told us that although there is currently no agreement in place, ongoing discussions are underway with NHS Greater Glasgow and Clyde regarding a formal service level agreement for access to beds for patients from NHS Western Isles with complex and challenging needs. They told us this is challenging as patients can sometimes remain in the unit despite requiring a more secure or intensive environment to meet their needs. Additionally, when beds do become available, they can be some distance from the Western Isles meaning potential challenges for the patient and their families to maintain contact.

Admission to specialist beds for those with complex and challenging needs are negotiated with the receiving health care provider on an individual basis using an extra contractual referral process. Extra contractual referrals allow patients to receive treatment outside standard healthcare contracts when necessary services are unavailable locally. This means they may be transferred to another health care provider, who can provide the specialist care. In incident reports submitted we observed one patient requiring transfer out of NHS Western Isles to meet their care needs, and this appeared to be arranged and carried out promptly. However, NHS Western Isles must ensure there is a clear process and agreement that enables care to be delivered to the people of the Western Isles by the most appropriate service in a timely manner. A requirement has been given to support improvement in this area.

Specialist admissions such as those under the care of the Child and Adolescent Mental Health Services who require admission to hospital can access the regional or national specialist services on the mainland. We saw no evidence of admission of a child or young person to the Acute Psychiatric Unit in the past six months and were told any patients under 16 years of age are admitted to the paediatric ward with support from the child and adolescent mental health team while awaiting admission to specialist units. For other patients who require specialist input such as treatment for eating disorders or those in the perinatal period, senior managers told us of an extra contractual referral process in place to access specialist beds within NHS boards or independent providers of healthcare. This is done on an individual basis to meet the needs of the patient.

In evidence provided we observed that the psychiatric liaison nurse is part of the full-time establishment for the Acute Psychiatric Unit. Staff from the unit also run a monthly clozapine clinic. Clozapine is an atypical antipsychotic medication primarily used to treat treatment-resistant schizophrenia and requires close monitoring due to the risk of significant side effects. Senior managers told us that an extra staff member is rostered on to facilitate the clozapine clinic. They also told us that the psychiatric liaison nurse provides cover in the unit if needed and

any impact on the liaison service will be discussed at the morning huddle. In the event of this happening any assessments that were due to be carried out by the liaison nurse can be done by medical staff or postponed until the following day.

NHS Western Isles currently have two locum consultant psychiatrists who are responsible for child and adolescent, older adult and adult mental health care across inpatient and community settings. We asked senior managers about longer term plans for medical provision and professional support for locum consultants. Senior managers told us of ongoing work in collaboration with Scottish Government and the Mental Welfare Commission to ensure appropriate provision of specialist doctors across NHS Western Isles mental health services. This includes a review of current job descriptions with options for alternative specialist roles and a risk assessment regarding the high reliance on senior medical staff to provide medical input across all mental health services in NHS Western Isles. Senior managers also told us of appraisal and revalidation processes in place with ongoing work to implement a 360-feedback tool for the locum psychiatric consultants as part of an assurance process required by NHS Western Isles. A 360-feedback tool is an assessment of performance that gathers information from multiple sources including peers and managers to provide a comprehensive view of an individuals strengths and areas for improvement.

Psychology input is provided following direct referral from the psychiatrist and is delivered remotely. Although psychology input is limited when patients are in the Acute Psychiatric Unit due to the acute nature of their illness, staff told us that there is a fortnightly multidisciplinary team meeting that includes psychology input and provides an opportunity to support staff in caring for patients with complex needs.

Access to allied health professionals is through referral and staff told us that occupational therapy, physiotherapy and dietetic services are responsive when referrals are completed.

Management of violence and aggression is essential to promote patient and staff safety. We asked staff how incidents of violence and aggression were managed safely within the unit. Staff explained that where necessary, Police Scotland were called to assist with any incidents that staff are unable to manage. All staff have access to an alarm system integrated into the ward environment to allow staff to respond promptly to any emergency situations. We heard from senior managers that when alarms are activated, staff across Western Isles Hospital are the initial responders. This includes the health and safety team who are responsible for providing the management of violence and aggression training for staff and are based within the hospital within business hours.

In evidence provided we observed that compliance with face-to-face violence and aggression training, which would be considered mandatory for staff within the Acute Psychiatric Unit, is 57% with the eLearning component of the training at 100%. Managers provided evidence that all staff in the Acute Psychiatric Unit are

booked on training which is being provided throughout April 2026. Clinical support nurses who provide 24-hour nursing cover for the hospital are also being trained in management of violence and aggression to respond during out of hours, including in the use of restraint. NHS Western Isles have set a target date of May 2026 for all staff to complete the training. Incident reports provided for the last six months show only two incidents reported as violence and aggression. We asked senior managers for levels of training for supplementary staff and staff throughout the hospital who may be responding to incidents within the Acute Psychiatric Unit. We were told most of the staff in the nursing bank are substantive staff so already meet the same requirements for violence and aggression training, and the training is also being provided for all bank staff who do not currently meet the requirements. NHS Western Isles must ensure that staff who are tasked with responding to incidents of violence and aggression are suitably trained and competent to safely carry out their role. A requirement has been given to support continued improvement in this area.

We requested compliance rates for all mandatory staff training within the Acute Psychiatric Unit. From this we observed eLearning compliance with adult and child protection is 100%, manual handling is 100% and fire safety is 92%. However, compliance with the mandatory practical element of basic life support and immediate life support training was 0%. Staff told us that all registered mental health nurses within the Acute Psychiatric Unit are required to complete immediate life support training and are given annual bespoke training for specific mental health scenarios such as asphyxiation from ligatures and self-harm. This was last carried out in December 2024 and is scheduled to be repeated in April 2026. Immediate life support training teaches more advanced skills than basic life support training including airway management. Unregistered staff attend basic life support training. We asked senior managers for an update during our virtual discussion. In additional evidence submitted, we observed that updated compliance with immediate life support was 43% and basic life support remained at 0%. In the event of an emergency, we were told the hospital arrest team would respond to an emergency call. Senior managers told us that dates for basic and immediate life support training have been arranged in late April 2026. There was no evidence of any incidents relating to this within the incident reports reviewed. A requirement has been given to support ongoing improvement in relation to training for staff who work in the Acute Psychiatric Unit.

Within evidence reviewed we noted physical restraint was commonly used to prevent incidences of self-harm. Within incident reports submitted for the six months prior to the inspection, 47% were incidents of self-harm. Scotland's Self-Harm Strategy and Action Plan (2023-2027) highlights that self-harm is complex and varies widely from individual to individual and can serve a variety of functions. These can include a form of self-punishment, compulsive or habitual behaviour and distraction from distressing emotions. We were provided with evidence of staff interventions during periods of patients attempting to carry out self-harm.

These included reassurance and de-escalation, support with breathing techniques to regulate emotion, and administration of prescribed medication to lessen distress. We also observed physical observations being monitored following incidents of self-harm and distress.

NHS Western Isles provided evidence of a group convened in November 2025 to address critical issues of security, detention and containment of patients within the Acute Psychiatric Unit. The focus of this group was to consider how best to balance safety and security for staff and patients with consideration of the challenges in a rural setting, while ensuring principles of the Mental Health (Care and Treatment) (Scotland) Act 2003 around least restrictive practice are adhered to. Actions from this group include the development of a locked door policy and a combined enhanced observation and short-term seclusion policy. Both are currently in draft form.

Seclusion, whether in hospital or other settings, is a form of restraint that requires careful management by an agreed decision-making process. It must be monitored by mental health and learning disability professionals and staff who are fully trained in the prevention and management of behaviour which may cause harm to others. There were no incidents of seclusion reported within the six months prior to the inspection. In minutes of the security, detention and containment meeting for the Acute Psychiatric Unit we observed discussions about the potential use of seclusion. We asked NHS Western Isles for a timeframe for completion of the policy regarding seclusion. Senior managers told us that there is still ongoing discussion about the use of seclusion, if necessary, within the Acute Psychiatric Unit and this would be included in the final version of the continuous intervention and short-term seclusion policy.

The use of enhanced observations is the practice used to support patient safety and individual care to reduce the risk of harm to themselves or others. Best practice guidelines are contained in Healthcare Improvement Scotland's Scottish Patient Safety Programme: From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care (2018). This guideline recommends a framework of proactive responsive and personalised care that focuses on prevention and early intervention in the context of a patients deteriorating mental health with a move away from the historical practice of enhanced observation. We observed evidence of the use of enhanced observations within the incident reports. At the time of inspection there were no patients on enhanced observations. The unit had not yet implemented the best practice guidelines mentioned and staff told us of three levels of observation from general hourly checks to more intensive support with constant and special observation. We requested a copy of NHS Western Isles' clinical observation policy. As mentioned above, the NHS Western Isles continuous intervention and short-term seclusion policy is currently in draft form. This is also being developed in line with Healthcare Improvement Scotland guidelines and the Mental Welfare Commission good practice guidelines on the use of seclusion. We

asked senior managers for a timeframe of implementation and how staff are being supported to develop observational practice and the safe use of seclusion in line with the guidance. They told us that discussions were ongoing, but we noted in the action plan submitted to the Mental Welfare Commission following their visit in April 2025 that May 2026 was the current timeline for board approval. Senior managers told us that there is also ongoing discussion about what training would be required to support the effective role out of the policy. A requirement has been given to support improvement in this area.

Within incident reports submitted, we observed one incident which required the main door of the ward to be locked temporarily to ensure the safety of patients and staff. We asked senior managers for a timeframe for completion for the draft "locked door" policy submitted regarding ingress and egress to the Acute Psychiatric Unit who explained the implementation of the policy is ongoing. As mentioned earlier, a requirement has been given to ensure oversite of the development of policies to align with best practice guidelines.

During the onsite inspection, we observed that plastic bin liners were being used in the bins in the main corridor of the Acute Psychiatric Unit. We asked staff about the use of these on the ward. They told us that these were only used in areas with high staff visibility. In evidence submitted in the past six months we observed that an incident of self-harm was recorded in relation to the use of plastic bags. We asked senior managers if there is a risk assessment in place for the use of plastic bags, including bin liners on the ward. Senior managers told us that there was no risk assessment currently in place but following the incident staff had been asked to ensure plastic bags were not brought onto the ward by both patients and visitors. NHS Assure Safety Action Notice 2403 highlights the steps mental health services should take to reduce the risk of suicide and self-harm involving plastic bags. This includes ensuring a risk assessment is in place with access to plastic bags being clearly identified using a risk scale from restricted to safe to use. NHS Western Isles must ensure the risk posed by plastic bags on the Acute Psychiatric Unit is captured and mitigated consistently by staff. A requirement has been given to support improvement in this area.

Annual ligature risk assessments are part of an ongoing programme of assurance within NHS hospitals to reduce the number of incidences of self-harm or suicide by identifying potential ligature points and the controls and mitigations in place to reduce identified risks. Inspectors observed that anti-ligature doors and windows had been fitted to all bedrooms and ensuite toilets. The beds in patient rooms were also weighted to reduce potential ligature points. Staff told us that the alarms on the bedroom doors were very sensitive to pressure and had been activated when cleaning or applying pressure on two occasions. We asked NHS Western Isles how the doors were maintained and if this had been reported as a concern. They explained that the doors are under warranty and would not have a maintenance contracted until this expires. We raised this with senior managers who provided assurance of monitoring the alarms being set off erroneously.

NHS Western Isles provided the most recent ligature risk assessment for the Acute Psychiatric Unit. Within this we observed areas being assessed as high, medium or low risk depending on likelihood of use of a ligature and potential consequences with current controls added. Current controls are interventions which identify and mitigate the risk of self-harm and suicide within the ward environment. These include clinical risk assessments and use of enhanced observations where risk is identified. We were also provided with the NHS Western Isles management of ligature risk policy which outlines the responsibilities of staff with regards to safe management of ligatures. We also observed that risk related to ligature points was on the operational service delivery team risk register which highlighted that the action plan for works within the Acute Psychiatric Unit to reduce ligature risks had been completed. Senior managers explained the ligature risk assessment is completed every six months, and the health and safety team do an onsite inspection every three months, including identification of potential ligature points. We asked about staff training in ligature risk management as outlined in the ligature risk reduction procedure for the Acute Psychiatric Unit. However, only some staff were provided with training by the company that supplied the anti-ligature doors when they were initially fitted, and no further training has been provided in relation to identification and mitigation of ligature risks. NHS Western Isles must ensure that staff have an awareness of ligature risks and how these are mitigated. A requirement has been given to support improvement in this area.

In evidence submitted we were provided with a fire risk assessment for the Acute Psychiatric Unit completed in October 2025. Following the NHS acute hospital follow up inspection in October 2025, a requirement was given in relation to low compliance of mandatory fire training and fire evacuation training. NHS Western Isles fire evacuation training may be in the form of an organised multiagency exercise, a walk and talk exercise as part of mandatory fire warden training or a desktop exercise. Acute Psychiatric Unit staff eLearning training compliance for fire safety was 92%. However, fire warden practical training was 43% with further training planned in March 2026. A requirement has been given to support improvement in this area.

Within evidence provided there were several incidents of patients absconding through the fire exit within the Acute Psychiatric Unit. We noted on one occasion the door was secured using a padlock and chain. This was highlighted as an unacceptable risk by the health and safety team and plans for a safer system for securing the fire door was discussed. However, there was a significant delay in fitting the new system with the concern highlighted in October 2025 and work commencing in January 2026. We asked senior managers for an update on this, and they confirmed that this has been resolved by the installation of door fittings that provide a balance between security and safety in the event of a fire and meet the legislative requirements of the Scottish Health Technical memorandum 81 and the Fire Safety (Scotland) Act. A requirement has been given in relation to estates responsiveness in Domain 4.1.

Requirements

Domain 1	
1	NHS Western Isles must ensure effective and appropriate governance approval and oversight of policies and procedures are in place.
2	NHS Western Isles must ensure staff are supported to care for patients that are not aligned with their specialty.
3	NHS Western Isles must ensure there are clear processes in place to ensure patients can access appropriate inpatient care when their needs are complex and cannot be met in current inpatient mental health facilities in the Western Isles.
4	NHS Western Isles must ensure that all staff are suitably qualified and competent to safely carry out their role through compliance with mandatory and role specific training including but not limited to immediate and basic life support, management of violence and aggression, continuous observations and the safe use of seclusion.
5	NHS Western Isles must ensure compliance with Safety Action Notice 2403 and staff can identify and mitigate the risk posed by plastic bags in the unit.
6	NHS Western Isles must ensure staff are trained in ligature risk management in line with NHS Western Isles Ligature Risk Reduction Procedure for the Acute Psychiatric Unit.
7	NHS Western Isles must ensure staff carry out mandatory fire evacuation training in line with fire safety risk assessment.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

Staff we spoke with described visible, supportive leadership and effective teamwork with access to debriefs following incidents, and support for staff wellbeing. Areas for improvement identified include ward level audit and assurance processes.

Staff we spoke with described a positive and supportive workplace and told us that NHS Western Isles was a good place to work. Staff told inspectors that communication within the unit was good. Information is shared during handover and any outcomes from audits or changes to policy are shared by the senior charge nurse through emails and at staff meetings.

Staff described feeling well supported when they escalate issues such as low staffing numbers and increased acuity. We observed NHS Western Isles escalation policy clearly displayed in the staff office in the ward. This supports staff in and out of hours to escalate any staffing concerns to senior managers. This is discussed further in Domain 4.3.

The personal development planning and appraisal process provides a framework for managers to give feedback and support to staff resulting in a more positive work culture. In evidence provided we noted that 85% of staff across the mental health unit had completed their appraisal and 77% of Acute Psychiatric Unit staff are up to date with clinical supervision. Senior managers told us that these figures are due to long-term absences and will continue to be monitored.

NHS Western Isles framework for adverse event reporting, management and learning has embedded the Healthcare Improvement Scotland's Learning from Adverse Events National Framework (2025). Further information on the national framework can be found here.

This is currently in draft form with work ongoing to embed the updated national framework. As described within national framework, all adverse incidents should be reviewed with the level of the review determined by the category of the event and is based on the impact of harm, with the most serious requiring a significant adverse events review. NHS boards should ensure immediate access to support for staff involved in adverse events. A debrief or discussion that takes place immediately following the event is an important element of staff support. This is an opportunity to ensure there are no immediate patient safety risks, acknowledge what has happened and support staff wellbeing. There were no significant adverse event reviews being carried out at the time of the inspection.

Staff described a culture where wellbeing was promoted following any incidents or adverse events which may occur within the service. They told us that they were confident in reporting any incidents through the current process, describing the use of the hot debrief and peer support to support and promote psychological safety following incidents on the Acute Psychiatric Unit. Also need-to-talk sessions are available within the hospital and support from occupational health, if required.

Staff report incidents through an electronic reporting system. These are then delegated to the appropriate investigator and once the investigation is complete, the outcome and any learning is shared with the original reporter. Staff receive feedback following submission of an incident report via email to confirm receipt, followed by a further email outlining the outcome of the incident review. Learning from incidents is also shared during ward handovers and discussed amongst staff. However, we noted that several incidents were linked together within the evidence submitted and these had not been individually closed off. This meant that learning from each individual incident may not have been fully identified. We raised this with senior managers who explained all incidents provided within the inspection evidence request had been closed and that incidents were sometimes grouped together if in relation to recurring incidents. While we recognise that recurring incidents can highlight themes and provide valuable learning, there is a risk that grouping incidents in this way may result in missed opportunities to learn from individual events. Additionally, this could limit the ability to reduce the risk

of harm reoccurring or escalating. When an adverse event occurs the focus must be on learning from what happened and improving the safety of patients and staff. A requirement has been given to support improvement in this area.

Clinical audits are required to monitor and enhance patient outcomes, promote safe and effective healthcare and identify areas for improvement and development. A regular programme of audit can support early identification of risks, support compliance with policy, and maintain patient and staff safety. In evidence provided there are audits for record keeping, care planning and student learning. Record keeping and care planning audits are completed at ward level and feedback given directly to staff. Information on student learning is submitted to the electronic care assurance dashboard. Any required action, identified themes, and learning is raised through the quality and safety group. Improvements are also supported by the NHS Western Isles quality improvement team.

We noted that the frequency of record keeping audits is determined by previous scores using a red, amber and green (RAG) rating system. Audits with a score of 60% or below are reaudited monthly, scores of between 61 –80% will be reaudited every three months, scores between 81-90% are reaudited every six months and audits scoring above 90% are reaudited annually. The record keeping audit was completed in January 2026 for the Acute Psychiatric Unit and scored 91% and will therefore be repeated annually. Within the audit we noted several areas identified as requiring improvement, including the consistent documentation of the status of individuals under the Adults with Incapacity Act. This was highlighted as an issue by the Mental Welfare Commission following their visit in April 2025 and is part of the resulting action plan. Ongoing assurance that the recommendation in the Mental Welfare Commission action plan is being met is provided through the documentation audits. We discussed the frequency of current clinical audits with senior managers in relation to assuring adherence to policy and maintaining patient safety. They explained that areas for improvement are identified through the audit process. NHS Western Isles submitted an action plan with areas identified as requiring improvement in the record keeping audit completed in January 2026. Within this we observed evidence of audit results being shared with staff and actions to improve compliance in areas such as documentation of Adults with Incapacity status and patient's stories being completed. However, there were areas requiring improvement that were not addressed in the care plan such as evidencing patient agreement with their care plan and information on accessing advocacy.

NHS Western Isles also submitted the Excellence in Care mental health person centred care planning audit completed in March 2026. Excellence in Care is Scotland's national care assurance programme designed to ensure high-quality, person-centred care through structured measurement, leadership development and continuous improvement. We requested the action plan for areas identified as requiring improvement. This was in relation to patient involvement in care

planning. However, we were not provided with this. A requirement has been given to support improvement in ward level assurance and learning.

Requirements

Domain 2	
8	NHS Western Isles must ensure learning from all incidents is used to improve safety and outcomes for patients and staff.
9	NHS Western Isles must ensure clear assurance processes and systems that identify required learning and actions taken to support improvement.

Domain 4.1 – Pathways, procedures and policies

Quality indicator 4.1 – Pathways, procedures and policies

Patient care documents including risk assessments within the Acute Psychiatric Unit were handwritten which meant that clear identification of clinical risks could be challenging. Areas for improvement have been identified including maintenance of the healthcare environment.

The Acute Psychiatric Unit currently uses written paper consultation notes and care plans while community mental health services in NHS Western Isles document care and treatment on an electronic system. NHS Western Isles told us there were no plans to introduce the same system within the Acute Psychiatric Unit. We asked senior managers about the challenges of ensuring sufficient information is shared between community and inpatient mental health services. They told us that consultation notes and recent assessments will be printed out prior to the admission of a patient known to the community mental health services. There are no guidelines in place to identify what information is required to support the transition of patients from community to inpatient. However senior managers told us of improvement work ongoing in this area. This is in the early stages, and a staff member has been identified as lead for implementing improvements using resources from the current work being undertaken by Healthcare Improvement Scotland to support transition from hospital to community within mental health services.

During the inspection, inspectors observed that care plans were complete and patient care notes about ongoing care and treatment were in depth. However, clinical risk assessments that had been completed on admission by medical staff were difficult to read due to them being handwritten. This was highlighted in the Mental Welfare Commission's findings following their visit in April 2025. We raised this with senior managers who stated that the risk assessments should be typed out and compliance with this action would be captured in the documentation audit. However, as discussed in Domain 2, the frequency of audits and action planning may not be sufficient to provide assurance that improvements are actioned and maintained.

Risk assessment and management are a fundamental part of clinical practice within mental health services. Assessment should include dynamic and situational factors which contribute to a better understanding about how, when and why risk events may occur. Risk management is an ongoing process involving patients and the multidisciplinary team working collaboratively to identify and reduce potential risks. Staff told us that clinical risks are updated weekly during the multidisciplinary team meeting and recorded in the meeting outcome proforma. Staff we spoke with told us that risk is informally assessed daily. However, although risks could be captured within consultation notes, there is limited evidence of ongoing formal risk assessment and management by nursing staff. This means that changes in risk and management of risk may not be easily evident within patient notes. A requirement has been given to support improvement in the consistent and accurate documentation of risk assessment and management within the Acute Psychiatric Unit.

People who experience significant mental health problems are at a considerably higher risk of developing physical health problems than the general population. We saw evidence of ongoing physical health monitoring and monitoring of physical observations following reported incidents of self-harm. Initial screening of falls risk and nutritional status were also evident. However, we observed no evidence of screening regarding skin integrity. We discussed this with senior managers who advised that not all patients undergo assessment and it is dependent on the needs of the patient. Healthcare Improvement Scotland's standards for the prevention and management of pressure ulcers (2020) identifies key standards for organisations to meet regarding the safe identification and management of pressure ulcers. This includes all patients admitted to a care service undergoing initial screening for risk related to pressure ulcers to prevent and reduce the likelihood of developing these. A requirement has been given to support improvement in this area.

Patient information was available on the Acute Psychiatric Unit. The Mental Health (Care and Treatment) (Scotland) Act 2003 also highlights that every person with a mental illness should have the right to access independent advocacy services. Information on accessing advocacy services was available throughout the unit. Mental health advocacy provides independent support for individuals with mental health needs. We noted in evidence that only 60% of patient's documentation evidenced discussion with staff around their right to access independent advocacy. As discussed in Domain 2, an action plan was submitted in evidence but there was no reference to noncompliance around information provided directly to patients to access independent advocacy.

Standard infection control precautions include patient placement, hand hygiene, the use of personal protective equipment (such as gloves and aprons), management of the care environment, safe management of blood and fluid spillages, linen and waste management and prevention and exposure management (such as sharps injuries). We observed good compliance with

infection prevention and control precautions including linen, waste and sharps being managed well.

Patient care equipment was clean and ready for use. Storerooms, including the medication preparation room, were tidy and well organised.

The bedroom areas were newly refurbished to reduce ligature points, and these were clean but stark in appearance. The overall ward environment appeared clean with some wear and tear evident in ensuite shower areas including areas which were not sealed around the skirting. Damage to healthcare environments can impact effective cleaning and create a risk that a patient or member of staff could be injured. Staff told us that estates are generally responsive to any requests for repairs. However, in incident reports submitted we identified a three-day delay in repairs being actioned for the lock on the main door of the unit and significant delays in work being carried out to safely secure the fire exit as mentioned in Domain 1. This appeared to have a direct impact on patient and staff safety. In incidents submitted we observed several incidents of patients attempting to abscond through the fire exit with staff having to intervene to maintain safety and encourage or direct patients back to the ward during this time. A requirement has been given to support improvement in this area.

Requirements

Domain 4.1	
10	NHS Western Isles must ensure that all patient documentation is clear, and accurately and consistently completed with ongoing actions recorded. This includes clear identification of risk and ongoing risk management.
11	NHS Western Isles must ensure there is oversight and consistent application of screening tools to identify patient risk of pressure damage in the Acute Psychiatric Unit.
12	NHS Western Isles must ensure they have systems in place to assure themselves that essential maintenance works are completed timeously, the care environment is maintained to allow for effective cleaning and any risks to patients and staff are identified and managed.

Domain 4.3 – Workforce planning

Quality indicator 4.3 – Workforce planning

NHS Western Isles have several standard operating procedures to support real-time staffing. Improvements in the completion and application of the common staffing method are required to ensure appropriate safe staffing levels and skill mix.

Workforce pressures including recruitment and retention of staff continue to be experienced throughout NHS Scotland. Workforce data submitted by NHS Western Isles for January 2026 demonstrates an overall nursing vacancy rate of

7.5% within the Mental Health Unit in the Acute Psychiatric Unit and a total sickness absence rate of 21.7%. We consider a high vacancy rate to be greater than 10% with the aim to achieve a sickness absence rate of 4% or less.

NHS Western Isles have unique challenges around both the low number of the existing staffing team in the five bedded unit and the requirement for supplementary staff with those who are working substantively making up a significant proportion of the nursing bank staff within mental health services. Additionally, if agency staff are required they are sourced from mainland Scotland and therefore there may be delays in staff arriving to cover any deficits. We observed high levels of supplementary staff usage within the Acute Psychiatric Unit and staff being moved within the hospital to mitigate any staffing deficits. We asked NHS Western Isles how they ensure supplementary staff are appropriately trained to work in the Acute Psychiatric Unit. As discussed in Domain 1 bank staff are currently being given access to attend training regarding prevention and management of aggression. When agency staff are used to cover staff deficits within the Acute Psychiatric Unit, NHS Western Isles stipulate that staff must be up to date and competent in management of violence and aggression and confirmation of this is received prior to staff being accepted for shifts.

NHS Western Isles has developed a number of standard operating procedures to support staff in the use of the electronic staffing system which records real time staffing numbers, including skill mix, and considers patient acuity. NHS Western Isles introduced an electronic staffing system which reports real-time staffing requirements based on professional judgement in relation to patient care needs. This provides a traffic light system with red areas having the highest shortfall of staff available to meet patients' needs. This enables informed decisions to be made when reorganising staff to help mitigate risk. This system considers the acuity of the patients versus available staffing numbers. It also allows for professional judgement to be made in terms of required staffing. The electronic staffing system informs discussions and decisions in relation to staffing and is utilised at their safety huddles where any mitigations or actions are recorded. Staff in the Acute Psychiatric Unit told us they use this system to record real time staffing including levels of acuity and dependency within the ward.

During the inspection we attended the morning hospital safety huddles where staffing requirements and shortfalls were discussed. We observed representation from nursing and allied health professionals across the hospital. There was representation from the Acute Psychiatric Unit who identified an incident that required additional staffing support for the ward to mitigate the identified risk. In response, the psychiatric liaison nurse was based within the unit for the remainder of the day. However, there was no detail around the identified risk and how this would affect staffing throughout the day or patient care needs. We asked NHS Western Isles for more detail about what was put in place to support staff and patients. We were told that staff met with the associate director of mental health and learning disability to clarify if any further assistance was required. Staff

supported the patient to reduce distress and ensured monitoring of physiological signs was in place post incident.

In evidence provided we observed two incident reports regarding staffing concerns over the last six months. These were both in relation to requirements for additional staff based on an immediate change in the acuity in the unit. On both occasions this was escalated to the clinical support nurse and on one of the occasions, resolved by the immediate use of community staff and review of staffing over the subsequent shifts. However, there were concerns noted around the impact of this on staff in relation to working a high number of hours. In evidence provided we also observed that staff were not always getting breaks in the evenings or during nightshifts due to staffing numbers. We asked senior managers how resilience is managed on occasions where acuity is unexpectedly increased due to admissions or enhanced observations and how they monitor and manage the impact of long hours and no break times. We were advised that improved systems are in place following the acute hospital inspection in September 2024.This includes monitoring staff wellbeing including missed breaks. Staff are encouraged to record any missed breaks on the incident reporting system, and any staffing risks and mitigations are discussed as part of the morning huddles. Clinical support nurses also often cover breaks if required within the Acute Psychiatric Unit. NHS Western Isles must ensure sufficient staffing to support patient safety and staff wellbeing. A requirement has been given to support improvement in this area.

The application of the common staffing method and staffing level tools enables NHS boards to ensure appropriate staffing levels, the health, wellbeing and safety of patients and the provision of safe and high-quality care. The Health and Care (Staffing) (Scotland) Act 2019 stipulates that health boards have a duty to follow the common staffing method. This is a multifaceted triangulated approach which includes the completion of a staffing level tool run to support boards to ensure appropriate staffing. The Acute Psychiatric Unit participated in the redevelopment of the mental health and learning disability inpatient staffing level tool, including testing in November 2024. NHS Western Isles provided us with the common staffing method report for the Acute Psychiatric Unit completed in December 2024 which highlights clinical challenges including the management of complex and challenging patient needs and the use of enhanced observations. Within the report there were gaps in provision of service specific information for accurate triangulation, including but not limited to, real time staffing risk, staff engagement and opinion and the impact of low staffing numbers in such a complex environment. The next Acute Psychiatric Unit tool run is scheduled for April 2026. From evidence received we could not gain assurance of the consistent or robust application of the common staffing method within inpatient mental health services. This was also apparent in findings of NHS Western Isles acute and maternity inspections in October 2025 where requirements were given regarding

the application of the common staffing method. A requirement has been given to support improvement in this area.

Staff told us that senior nurses occasionally work clinically to cover staffing shortages and support the clinical team in times of high acuity. Time to lead is a legislative requirement under the Health and Care (Staffing) (Scotland) Act (2019). This is to enable clinical leaders to ensure they have protected time and resource to ensure appropriate staffing alongside other professional duties to lead the delivery of safe, high quality and person-centred healthcare. Although the senior charge nurse occasionally works clinically, they are rostered on daily as supernumerary and this ensures they have sufficient time to lead.

A plan to develop a robust system of workforce support, nurturing leadership to prepare staff to take on senior leadership roles is outlined within the National Workforce Strategy for Health and Social Care in Scotland. More information can be found here. During onsite inspection with senior managers, we discussed the challenges of senior leadership roles within mental health in the remote and rural areas. The Mental Welfare Commission's visit in April 2025 highlighted a gap in senior nursing leadership which may impact capacity for effective governance, quality assurance and support for nursing staff. A requirement in relation to assurance processes has been given in Domain 2.

There are regular senior charge nurse forums within Western Isles Hospital to provide support for those in the role. However, senior managers explained the lack of a mental health lead nurse has resulted in staff in current senior leadership roles within mental health services to take on tasks that would potentially be led by those in a lead nurse or equivalent role. We discussed this further with senior managers who explained responsibilities are shared by those in Band 7 roles across mental health services and although no current changes are being considered any developments within the leadership structure would be considered through the longer-term workforce plan. The Health and Care (Staffing) (Scotland) Act 2019 states that health boards have a duty to ensure safe, high quality, person-centred service provisions through having the right staffing in place.

Requirements

Domain 4.3	
13	NHS Western Isles must ensure sufficient staffing, with the right staff in place to support patient safety and staff wellbeing.
14	NHS Western Isles must ensure that there are processes in place to support the consistent application of the common staffing method. This includes that the principles of the common staffing method are applied, including having a robust mechanism for feedback to be provided to staff about the use of the common staffing method, and staffing decisions made as a result.

Domain 6 – Dignity and respect

Quality indicator 6.2 – Dignity and respect

Inspectors saw evidence of therapeutic interventions to reduce distress and the impact and frequency of self-harm. Patients in the Acute Psychiatric Unit should have access to a locked bedroom space to maintain and protect privacy and dignity. Areas for improvement include the care planning and provision of meaningful activity.

Patients we were able to talk with were positive about the care they received from nursing staff within the Acute Psychiatric Unit, describing care as responsive and the environment as a safe space. However, they felt that changes to their treatment had been commenced without their input and they were concerned about the impact. We fed this back to staff during the inspection. As part of evidence provided, we observed that the person-centred care planning audit highlighted that evidence of patient involvement in care planning was 60%. We asked senior managers for the action plan in relation to this however, this was not provided. A requirement has been given in relation to improving and evidencing patient involvement in planning care.

Evidence submitted demonstrated staff providing therapeutic interventions to reduce distress and support trauma informed care. The use of safety and stabilisation techniques were highlighted in incident reports in relation to reducing the impact and frequency of self-harm. Safety and stabilisation refers to the use of trauma informed interventions and strategies designed to help manage distress, maintain safety and develop psychological stability.

The provision of meaningful activity on mental health wards is said to increase social connectedness, improve psychological wellbeing and is essential to promote wellbeing and recovery. Staff told us that there was no timetable of activities and that therapeutic activities are planned and implemented on a person-centred basis. Meaningful activity was not included within patient care plans. In evidence provided we observed that due to low levels of staffing, activity provision can be limited. Senior managers told us about activity champions within the unit whose role is to develop and implement activities appropriate for the patient group. They told us this is challenging in such a small unit, and the focus was currently on developing 1:1 activity centred around individual needs. A requirement has been given to support improvement in this area.

We observed a suggestion box for patient feedback within the Acute Psychiatric Unit. Patient feedback is also sought through Care Opinion and the use of QR codes to provide easy access. Senior managers told us of the roll out in March 2026 of a questionnaire about patient experience which has been developed in line with the Core Mental Health Quality Standards (2023). This is given to patients on discharge and the responses from all feedback will be collated by the patient focus public involvement team.

The Acute Psychiatric Unit is a mixed sex ward with five ensuite rooms. Staff told us that they had encountered no issues regarding the placement of patients within the ward, and we saw no evidence of incidents reported. However, in evidence provided we noted there were no locks on bedroom doors. The mental health-built environment standards apply to all adult acute mental health wards and give best practice guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities. NHS Scotland Assure have developed an assessment toolkit based on the mental health-built environment standards to measure and help manage the complex challenges of care and accommodation for people who need in-patient mental health care in our NHS Scotland adult acute wards. To support patient dignity and privacy, the quality statements include patients being able to lock their bedroom door from both in and outside, with the capability for staff to override this to protect their safety. Work to ensure ligature reduced fittings within the Acute Psychiatric Unit was extensive and included the replacement of all bedroom doors. We asked senior managers about this who told us that there were ongoing discussions regarding being able to lock patient doors and that a decision had not yet been reached. NHS Western Isles must ensure patient privacy and dignity is maintained at all times and patients are given the choice to lock their bedroom door safely. A requirement has been given to support improvement in this area.

Areas of good practice

Domain 6	
1	Staff deliver trauma informed interventions to help manage distress and maintain safety.
2	A patient feedback questionnaire has been developed and is being rolled out to measure patient experience within the Acute Psychiatric Unit.

Requirements

Domain 6	
15	NHS Western Isles must ensure all patients are involved in planning their own care and this should be documented.
16	NHS Western Isles must ensure meaningful activity is consistently provided and evidenced within care planning documentation.
17	NHS Western Isles must ensure that patients' privacy and dignity is maintained, including having appropriate safe lockable bedroom doors that support dignity and privacy.

Appendix 1 - List of national guidance

The following national standards, guidance and best practice were current at the time of publication. This list is not exhaustive.

- Age and Frailty – Standards for the care of older people (Healthcare Improvement Scotland, November 2024)
- Allied Health Professions (AHP) Standards (Health and Care Professionals Council Standards of Conduct, Performance and Ethics, September 2024)
- Clinical Governance Standards (Healthcare Improvement Scotland, February 2026)
- Core Mental Health Quality Standard (Scottish Government, September 2023)
- Delivering Together for a Stronger Nursing and Midwifery Workforce (Scottish Government, February 2025)
- Fire Scotland Act (Acts of the Scottish Parliament, 2005)
- Food, fluid and nutritional care standards – Healthcare Improvement Scotland (Healthcare Improvement Scotland, November 2014)
- From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care (Healthcare Improvement Scotland, January 2019)
- Generic Medical Record Keeping Standards (Royal College of Physicians, November 2009)
- Health and Care (Staffing) (Scotland) Act (Acts of the Scottish Parliament, 2019)
- Health and Social Care Standards (Scottish Government, June 2017)
- Infection prevention and control standards – Healthcare Improvement Scotland (Healthcare Improvement Scotland, May 2022)
- Mental Health (Care and Treatment) (Scotland) Act (Acts of the Scottish Parliament, 2003)
- National Infection Prevention and Control Manual (NHS National Services Scotland, January 2024)
- Healthcare Improvement Scotland and Scottish Government: operating framework (Healthcare Improvement Scotland, November 2022)
- Prevention and Management of Pressure Ulcers - Standards (Healthcare Improvement Scotland, October 2020)
- Professional Guidance on the Administration of Medicines in Healthcare Settings (Royal Pharmaceutical Society and Royal College of Nursing, January 2019)
- Rights, risks, and freedom to limits (Mental Welfare Commission, March 2021)

- Standards for student supervision and assessment (Nursing & Midwifery Council, April 2023)
- The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing & Midwifery Council, October 2018)
- The quality assurance system and framework – Healthcare Improvement Scotland (Healthcare Improvement Scotland, September 2022)

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